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Sam Brownback, Governor

SEND TO: KANSAS DEPT. OF HEALTH & ENVIRONMENT

BUREAU OF WASTE MANAGEMENT 1000 SW JACKSON, SUITE 320 TOPEKA, KS 66612 (785) 296-1611

## APPLICATION FOR PARTICIPATION IN THE KANSAS MEDICATION DISPOSAL PROGRAM

NAME OF PHARMACY		KS PHARM	ACY REG #
PHYSICAL ADDRESS	CITY	STATE	ZIP
MAILING ADDRESS (IF DIFFERENT	FROM ABOVE)		
TELEPHONE NUMBER		PHARMACIST IN CHAF	RGE
EMAIL ADDRESS			
Application is hereby made to participate in the Kansas Medication Disposal Program through the Kansas Department of Health and Environment. Upon acceptance, applicant shall receive an updated Certificate of Renewal indicating their participation in the program from the Kansas State Board of Pharmacy. The certificate should be displayed in the applicant's place of business. Registration in the program will expire annually and may be renewed at the time of the pharmacy's license renewal.			
By signing this application below, appl KDHE Kansas Medication Disposal Pr			orth in the
SIGNATURE OF PHARMACIST IN CI	HARGE	DATE	